



U.S. Department of Health and Human Services
Office of Inspector General

**Indian Health Service
Has Strengthened
Patient Protection
Policies but Must Fully
Integrate Them Into
Practice and
Organizational Culture**

OEI-06-19-00330
December 2019

oig.hhs.gov

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IHS Has Strengthened Patient Protection Policies but Must Fully Integrate Them Into Practice and Organizational Culture

What OIG Found

OIG found that IHS policies to prevent and address child sexual abuse included similar elements of policies developed by benchmark organizations.

Sufficiency of Policies. IHS included provisions for provider-patient boundaries, medical examination precautions, reporting responsibilities, and protections for patients and staff. In a few cases, IHS policies were stricter and more detailed than those of other organizations. However, IHS policies do not explicitly address other types of abuse, adult victims, or perpetrators who are not healthcare providers.

Implementation of Policies. Some IHS-operated healthcare facilities are early in implementation and have not updated their individual facility policies, largely due to staffing shortages and turnover of facility leadership. IHS has trained staff on its updated policies and provided outreach to Tribal communities, but faces challenges that may discourage reporting of abuse, including difficulty ensuring anonymity, fear of retaliation, and communication barriers (e.g., language, stigma), among others. In addition, we found significant shortcomings in IHS systems for storing and tracking patient abuse reports and confusion about roles and responsibilities related to such tasks. IHS has initiated efforts to strengthen systems and oversight.

What OIG Recommends and How the Agency Responded

To address these issues and further protect patients from abuse, we recommend that IHS:

- › extend policies to address more types of perpetrators, victims, and abuse;
- › ensure that the new incident reporting system is effective and addresses the risks identified in the current system;
- › designate a central owner in IHS headquarters to ensure clear roles and responsibilities for shared ownership in implementing patient protection policies, and managing and responding to abuse reports;

Key Takeaway

In early 2019, IHS updated its policies to prevent and address child sexual abuse by healthcare providers, strengthening patient protections and IHS staff reporting responsibilities. These policies are now largely consistent with policies of benchmark organizations, but they have coverage gaps and are still early in implementation. IHS must expand its efforts to overcome challenges and integrate these policies into practice and organizational culture.

Why OIG Did This Review

In recent years, the Indian Health Service (IHS) has had a number of cases of healthcare providers abusing patients under facility care, including a pediatrician who was convicted of multiple counts of child sexual abuse. In February 2019, the Deputy Secretary of the Department of Health and Human Services requested that the Office of Inspector General (OIG) assess IHS policies and procedures for preventing, reporting, and addressing patient abuse. In the same month, the Senate Committee on Indian Affairs also requested that OIG review applicable IHS policies, procedures, standards, and other requirements intended to prevent and address misconduct. This study identifies strengths and gaps in IHS policies, and progress and challenges in their early implementation.

How OIG Did This Review

We based our findings on document reviews and interviews with 45 officials and staff at IHS headquarters and Area Offices, conducted in July–August 2019. We also reviewed IHS policies and other relevant documents and compared them to similar policies from three benchmark organizations: the American Academy of Pediatrics, the American Medical Association, and the National Council of State Boards of Nursing. Topics for our interviews with IHS officials and staff included implementation of IHS patient protection policies and procedures, strategies for and challenges to implementation, and other IHS improvement efforts related to preventing and addressing patient abuse in IHS facilities.

- › continue to actively promote an organizational culture of transparency, and work to resolve barriers to staff reporting of abuse; and
- › conduct additional outreach to Tribal communities to inform them of patient rights, solicit community concerns, and address barriers to reporting of patient abuse.

This evaluation also provides additional support and urgency to a prior OIG recommendation that IHS has not yet implemented. In July 2019, OIG recommended that IHS, as a management priority, develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals.

IHS concurred with our recommendations, and reported actions taken and planned to implement the recommendations, as of December 2019.

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BACKGROUND

Objective

To assess Indian Health Service (IHS) policies and procedures for preventing, reporting, and addressing patient abuse and identify progress and potential challenges to their effective implementation.

Indian Health Services

IHS is responsible for providing Federal health services to American Indians and Alaska Natives (AI/AN) and has an annual budget of \$5.6 billion.¹ In partnership with the 573 federally recognized Tribes, IHS provides free primary and preventive healthcare services to approximately 2.6 million AI/ANs living in the United States.² IHS's mission is "to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level."³

Recent cases of patient abuse by IHS employees have raised concerns about protecting the AI/AN population. The convictions of a former IHS pediatrician in September 2018 and 2019 brought attention to the issue and shed light on areas requiring improvement within IHS.^{4,5} At congressional hearings in April and May 2019, the IHS Principal Deputy Director noted that the agency does "not tolerate sexual assault and abuse in its facilities" and had begun efforts to ensure safe and quality care for its patients, including implementing stronger requirements for IHS employees to report suspected sexual abuse of children.^{6,7} IHS has also developed and enhanced systems that support identification of problem providers and patient abuse reporting.^{8,9}

Organizational Structure. IHS headquarters (HQ) provides general direction, policy development, and support to each of 12 Area Offices and their IHS-operated healthcare facilities, which may include hospitals, urgent-care clinics, and/or other types of facilities.¹⁰ Area Offices oversee the delivery of health services and provide administrative and technical support to the facilities. IHS maintains its current policies, procedures, and operating standards in the *Indian Health Manual* (IHM). IHS policy directs that the IHM is the primary reference for IHS staff regarding IHS-specific policy and procedural information.¹¹

IHS-Operated Facilities. IHS provides healthcare services to AI/ANs directly through IHS-operated facilities or provides financial support for the Tribes to operate their own healthcare systems.^{12,13} The IHS federal system of IHS-operated facilities includes 24 hospitals, 51 health centers, 24 health stations, and 2 school health centers.¹⁴

Medicare Conditions of Participation

IHS requires all IHS-operated facilities to be certified by the Centers for Medicare & Medicaid Services (CMS) or accredited by an accrediting organization that supports the reimbursement requirements established by CMS.^{15, 16} Among these requirements are the Conditions of Participation (CoPs), a set of minimum quality and safety standards. The CoPs include requirements such as establishing an effective governing body legally responsible for the performance of the facility, protecting and promoting patients' rights, and maintaining an organized medical staff responsible for the quality of patient medical care.¹⁷

CMS and accrediting organizations monitor IHS healthcare facilities' compliance with the CoPs through periodic onsite surveys.¹⁸ Surveyors observe how facilities provide care to patients, and assess whether that care meets the needs of the patients and is in compliance with all requirements. To indicate noncompliance, surveyors cite facilities with deficiencies that facilities must correct in a timely manner to continue participating in Medicare. If surveyors identify an "immediate jeopardy" (noncompliance with one or more requirements that caused, or is likely to cause, serious injury, harm, impairment, or death to a patient), the facility must immediately develop and implement a plan of correction to remove the immediate jeopardy or face termination from the Medicare program by CMS.¹⁹

Cases of Patient Abuse at IHS

Over the years, there have been several allegations of patient abuse committed by IHS employees, some of which have involved minors. For example, Stanley Patrick Weber, a former IHS physician was found guilty on September 6, 2018, of sexually abusing patients while he was a pediatrician at the Blackfeet Community Hospital in Montana between 1992 and 1995.^{20, 21} On September 27, 2019, Dr. Weber was also found guilty of sexually abusing minors at the Pine Ridge Hospital in South Dakota, where he worked from 1995 until he resigned in 2016.²² The crimes for which he was convicted occurred both at the hospital and in his home. This case was particularly troubling given that hospital staff raised suspicions, on multiple occasions, that Dr. Weber was abusing children, yet he continued to work as a pediatrician at IHS hospitals until his resignation, which allowed him to treat and victimize children for more than two decades.²³

In addition to Dr. Weber, other IHS healthcare providers have been accused of patient abuse over the last two decades. In 2013, IHS fired a physician after receiving complaints of sexual misconduct involving patients. In 2005, an adult patient sued a physician working under a term contract with IHS, for sexual assault; the suit was later settled out of court.^{24, 25} In 1999, IHS settled a lawsuit involving a teenage patient and an IHS psychologist.^{26, 27}

Request for OIG Evaluation

Dr. Weber's case has specifically raised concerns about IHS actions and efficacy of policies and procedures for addressing patient abuse in its facilities. In February 2019, the Office of Inspector General (OIG) received a request from the Deputy Secretary of the Department of Health and Human Services (HHS) to review IHS's newly implemented series of system-wide policies and procedures designed to promote a zero-tolerance for patient abuse. In the same month, OIG also received a congressional request asking OIG to evaluate applicable IHS policies, procedures, standards, and other requirements intended to prevent, address, and correct misconduct present in the Weber case.

IHS Actions to Address and Prevent Patient Abuse

As a result of the Weber and other patient abuse cases, IHS initiated several efforts in 2017 to further address and prevent patient abuse in its facilities.²⁸ In 2018, IHS leadership notified all staff of the agency's "zero-tolerance" policy, which prohibits staff from engaging in intimate physical relationships with patients and requires staff to report, investigate, and follow up on any concerns of patient abuse.²⁹ IHS also announced plans to train its Federal employees and contractors on how to identify and report suspicions of abuse based on system-wide reporting responsibilities. Additionally, IHS revised policy documents and systems, including methods for screening providers and reporting allegations of abuse.^{30, 31}

New IHM Policies on Preventing Child Sexual Abuse. In February 2019, IHS issued new policies in the IHM, entitled "Protecting Children from Sexual Abuse by Health Care Providers," which include guidance specific to provider interactions with children.^{32, 33} The policies serve as an update to prior policies about patient abuse in the IHM and also provide greater specificity, outlining roles and reporting responsibilities for leadership and staff at all levels of the agency to protect children from sexual abuse and exploitation in IHS-operated healthcare facilities.³⁴ They also include provisions for the use of chaperones during medical exams and guidance regarding staff rights.³⁵

Informed Patient Consent. The IHM has had guidelines for ensuring protection of patient rights related to informed consent since July 2010.³⁶ The policies, entitled "Health Information Management," contain a provision stating that "all health records must include evidence that informed consent was obtained from the patient or personal representative prior to undertaking any treatment or procedure."³⁷ If the patient is a minor, a parent or legal guardian may act on the patient's behalf and can consent or reject medical treatment.³⁸

Ethical Standards. The IHS Division of Personnel Security and Ethics (DPSE), formerly known as the Personnel Integrity and Ethics Staff, administers and manages ethics programs at IHS, including training and directives for the agency's ethical conduct standards.³⁹ Along with

following IHS policies, most IHS staff working in IHS-operated healthcare facilities must also adhere to Federal requirements for reporting suspected child abuse and neglect.⁴⁰

The IHM has had guidelines for reporting and responding to violations of ethical standards in place since August 2004.^{41, 42} The policies, entitled, "Ethical and Professional Conduct of Health Care Providers," detail the reporting structure for allegations of unethical conduct and state that "it is unethical not to report known violations of misconduct or violations of ethical standards."⁴³ The policies dictate that facility staff immediately report allegations of misconduct or violations of ethical standards to their supervisor or other appropriate officials, and the supervisors must then report the allegations to senior leadership in the facility and/or the Area Office. They also require that chief executive officers (CEO) of the IHS-operated facilities report all allegations to their respective Area Office, OIG, and/or DPSE. Once Area Offices are notified, the Area Directors must report the allegations to DPSE and/or OIG and to the appropriate professional organizations and State licensing/certification boards.⁴⁴

Reporting Allegations of Abuse. Under the most recent policies for protecting children from sexual abuse, all staff, including healthcare providers, with reasonable cause to suspect that a provider has sexually abused a child must report the incident to child protective services and/or law enforcement, as well as OIG.⁴⁵ IHS defines a healthcare provider as anyone who provides physical or behavioral health treatment to patients (e.g., physicians, nurses, dentists, psychologists).⁴⁶ All staff, including supervisors, are also responsible for ensuring that all reported incidents of inappropriate sexual contact are documented in the IHS incident reporting system.⁴⁷

In December 2018, IHS awarded a contract for a new adverse events reporting and tracking system to replace WebCident, IHS's longstanding incident reporting system.^{48, 49, 50} IHS plans for the new system to have an improved interface with various data collected from IHS-operated facilities, including patient safety errors and adverse events.⁵¹

IHS and OIG also provide telephone hotlines that IHS staff, contractors, patients, and others can use to file complaints and report allegations of patient abuse involving IHS staff.⁵² Callers can be anonymous and may use the hotlines to elevate concerns regarding fraud, waste, and mismanagement at IHS. Complaints and reports can also be submitted electronically on the IHS and OIG websites.^{53, 54}

Whistleblower Protections. The new IHM policies for protecting children from sexual abuse prohibit administrative or adverse action against an employee who reports an allegation.⁵⁵ Federal law further provides whistleblower protections to most Federal employees, Commissioned Corps Officers, and employees of Federal contractors, subcontractors,

grantees, and subgrantees. These protections bar retaliation for reporting protected disclosures, including violations of law.^{56, 57, 58} Officials who retaliate against whistleblowers may be subjected to corrective or disciplinary action to be imposed on those who retaliate against these individuals.⁵⁹ OIG has a Whistleblower Protection Coordinator (formerly “Ombudsman”), who is responsible for educating HHS employees on their whistleblower protections.⁶⁰

Patient Protection Policies from National Organizations

Other professional organizations have developed policies for preventing, reporting, and addressing patient abuse in healthcare settings, including:

- › [American Academy of Pediatrics \(AAP\)](#)
AAP works with government, community, and other national organizations on child health and safety issues and has developed detailed guidance for protecting children from sexual abuse by healthcare providers. It was founded in 1930 and is made up of about 67,000 pediatricians.^{61, 62}
- › [American Medical Association \(AMA\)](#)
AMA’s mission is to promote “the art and science of medicine and the betterment of public health” through advocacy and the use of its Code of Medical Ethics. The Code provides guidance for members about ethical principles of the medical profession, including for patient-physician relationships, consent, and communication.⁶³
- › [National Council of State Boards of Nursing \(NCSBN\)](#)
NCSBN promotes patient safety and public protection by providing education and research to its nursing regulatory bodies. These include bodies in the States, the District of Columbia, and U.S. territories that regulate more than 4.8 million licensed nurses.^{64, 65}

These nationally recognized healthcare organizations have a long history of providing policy guidance to various healthcare entities and have developed specific guidance on patient abuse.

Other External Evaluators of IHS Patient Protection Policies

In May 2019, IHS awarded a contract for an independent medical quality assurance review that will assess IHS adherence to laws, policies, and procedures aimed at protecting patients from sexual abuse.⁶⁶ The review will largely be retrospective and will include medical record reviews from 1986 to present. The independent contractor will identify system failures that may have contributed to IHS’s inability to prevent or address Dr. Weber’s patient abuse, as well as determine any further improvements that IHS can implement to better protect patients.^{67, 68}

The U.S. Government Accountability Office (GAO) also has work underway in this area, in response to a request from the Senate Committee on Indian Affairs in May 2019 to review IHS policies and actions for addressing and documenting personnel performance and misconduct

issues.^{69, 70} The Committee raised concerns about IHS use of transfers, duty reassignments, and administrative leave to address poor performance and misconduct, and asked GAO to determine the extent of such activity since 2010, when the Committee initially identified this issue. The Committee also requested that GAO assess whether a new centralized credentialing system adopted by IHS captures performance and misconduct information and is accessible across facilities.

Additionally, in March 2019, the White House formed the Presidential Task Force on Protecting Native American Children in the IHS System. The task force, comprised of top-level officials from the White House, U.S. Attorney's Office for the Northern District of Oklahoma, Bureau of Indian Affairs, Federal Bureau of Investigation (FBI), IHS, and Office of Management and Budget, meets periodically to discuss how to better protect AI/AN children from abuse while under the care of IHS. The Task Force's goal is to develop and recommend policies, protocols, and best practices for future implementation.⁷¹

Related OIG Work

This study expands on prior and ongoing work by OIG. Since 2016, OIG has focused largely on IHS management of hospitals, and issued companion reports describing lack of quality oversight and a number of challenges that affect IHS hospitals' ability to provide quality care and maintain compliance with Federal requirements.^{72, 73} Recently published OIG reports include a case study of IHS management of a 7-month closure of the Rosebud Hospital emergency department and a management review of IHS HQ operations and organizational challenges.^{74, 75} Other ongoing work includes a medical record review that will determine the incidence of patient harm (adverse events) in IHS hospitals. OIG plans to continue this body of work with a review of the implementation of IHS patient protection policies and procedures at the facility-level.

Scope of Inspection

This study examines the sufficiency and implementation of IHS policies and procedures to prevent, report, and address patient abuse. We inventoried and assessed IHS patient protection policies and procedures currently in place, with special attention to any policies added or updated since 2017 (when Dr. Weber was initially indicted). As part of our assessment of sufficiency, we compared IHS policies to the policies of three nationally recognized professional healthcare organizations (i.e., AAP, AMA, and NCSBN) as a benchmark.

We also examined IHS's progress in communicating and operationalizing these policies across the agency, facilities, and Tribal communities, including IHS officials' perspectives on challenges or barriers to full implementation of the policies into practice and organizational culture.

Methodology

Data Collection and Analysis

Interviews. We conducted interviews with 45 officials and staff at IHS HQ and Area Offices in July–August 2019 to inventory IHS’s policies and procedures on patient abuse, and other related improvement efforts. This included interviews with officials who were instrumental in developing and implementing IHS’s updated patient protection policies and new incident reporting system.

During these interviews, we discussed recent patient protection policy changes, communication with staff regarding the changes, strategies, and challenges for implementing the updated policies and procedures at the facility-level. We employed semi-structured interview protocols that allowed us to follow up on additional issues as we learned new information and identified key issues.

Document Reviews. We reviewed national IHS policies and procedures for preventing, reporting, and addressing patient abuse and supporting documentation outlining IHS implementation efforts. We also reviewed patient protection policies used by at least two of the three selected benchmark organizations to identify relevant policies for comparison with IHS policies.

Data Analysis. We conducted a qualitative analysis of interview data and policy documents to identify policy gaps and mechanisms in place to prevent, report, and address patient abuse.

Limitations

We did not assess potential breakdowns that contributed to the Weber case or review any earlier improvement efforts undertaken by IHS to address patient abuse before his indictment in 2017. Further, we did not review patient protection policies and procedures in tribally operated healthcare facilities.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

IHS has strengthened its patient protection policies, but gaps in coverage remain and some facilities have yet to update their local policies

The indictment of Dr. Weber ignited IHS's efforts to identify and mitigate gaps in its policies and procedures and enhance the protections of children from sexual abuse and exploitation by healthcare providers. In developing the 2019 policies, IHS officials reported researching best practices and consulting with stakeholders, such as the AAP Committee on Native American Child Health (CONACH), an advocacy group for AI/AN children comprised of pediatric providers.⁷⁶

The new policies apply to all providers, including those employed or contracted by IHS, and outline roles and responsibilities for leadership and staff at all levels of the agency to protect children from abuse in IHS's care. However, the policies do not explicitly address perpetrators who are not healthcare providers (e.g., administrative staff), other types of abuse (e.g., physical), or adult victims.

The development of the new policies is an important step to prevent and address patient abuse, but at the time of our review, facilities as a whole were still early in implementation, and some facilities had not updated their local policies and procedures to include the new agency guidelines.

IHS policies and procedures for preventing and addressing child sexual abuse by providers are now largely consistent with policies of benchmark organizations

With the addition of the new policies for protecting children from sexual abuse, we found that policies in the IHM closely aligned with the broader policies of the three healthcare organizations we selected for comparison: AAP, AMA, and NCSBN. IHS included provisions, similar to the benchmark organizations, for provider-patient boundaries, medical examination precautions, reporting responsibilities, and protections for patients and staff. In a few cases, provisions of the IHS policies were stricter or more detailed than those of the other organizations.

Provider-Patient Boundaries. The IHM provided guidelines for boundaries on romantic, social, and economic relationships between providers and patients. IHS longstanding policies on ethical and professional conduct of healthcare providers prohibited providers from engaging in romantic or sexual relationships with patients and outlined limitations around medical treatment of patients with whom the providers have a personal relationship, including the providers' family members.

The new IHS policy provisions on preventing child sexual abuse by healthcare providers included further directions for limiting communication between providers and patients outside of the professional setting and detailed different scenarios of inappropriate

contact and gifts. Those scenarios included providing childcare outside of the IHS facility, providing transportation in personal vehicles, inviting children to locations outside of the IHS facility (e.g., personal home), sharing personal information or problems, sharing personal contact information, interacting on social media, and taking or possessing images of patients on personal devices. We found that the IHS guidance was stricter than its counterparts regarding gifts. While the policies of the other organizations allowed providers to accept nominal gifts from patients, IHS prohibited any form of gift exchange between providers and patients.

Medical Examination Precautions. The IHM included provisions on precautionary measures for medical examinations, including guidelines for providing chaperones during medical exams and obtaining patient consent. The updated provisions stated that chaperones should be provided when requested by a patient, parent, or caregiver, and offered to minors during a medical exam. If a patient refuses a chaperone, a support person of the patient's choosing (e.g., parent, caregiver) could serve as an alternative.

The policy provisions also stated that any providers in "contact with or control over a child" who have a pending background investigation must be within sight and under the supervision of a chaperone with a favorably adjudicated background investigation on file. To help ensure that facilities follow these provisions, IHS officials reported that providers and their supervisors, as well as facility CEOs and Area Directors, must sign a provisional chaperone form for providers with a pending background investigation.

Longstanding IHS policies on health information management included guidance on informed consent, the process of ensuring that patients understand and agree with the examination and treatment. Obtaining patient consent and preparing patients for a medical exam or procedure, particularly one that involves the genital area, is important because patients may not know what to expect and therefore may not recognize if a provider is sexually violating them. In interviews, an IHS official reported that the agency was working to strengthen this provision following a recent incident at an IHS hospital, where local law enforcement ordered IHS staff to draw fluids from a patient who did not consent to the procedure. (See Exhibit 1 for further details regarding this incident.)

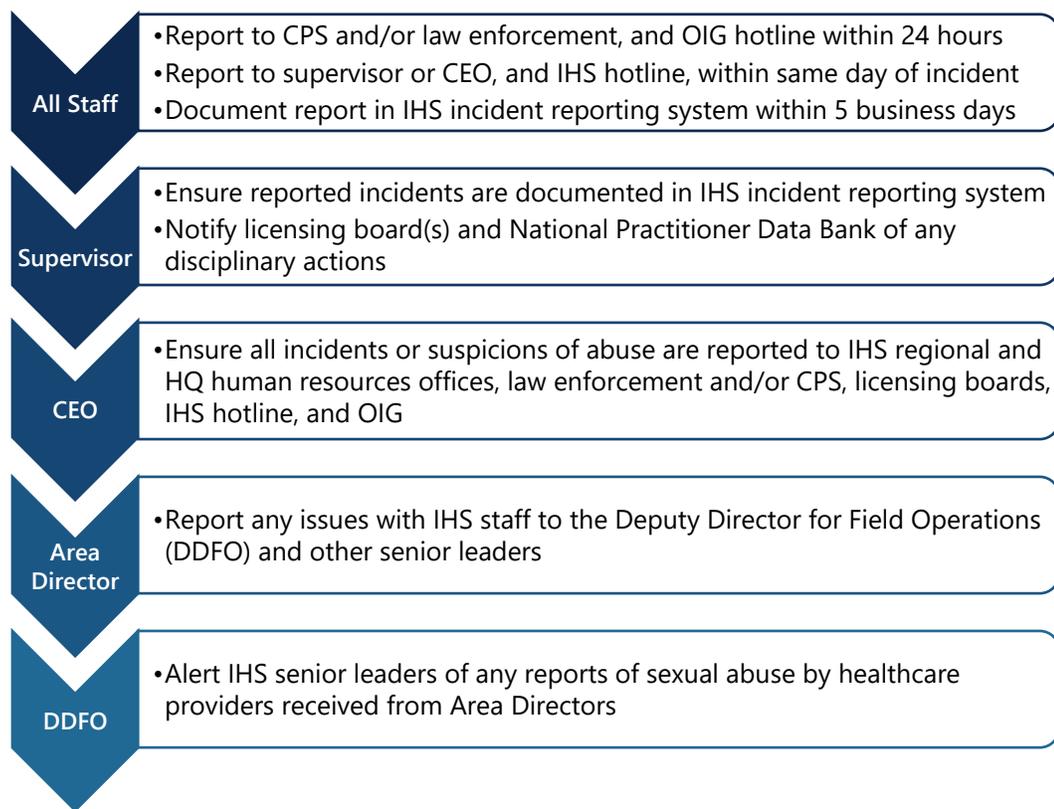
Exhibit 1: A recent patient consent incident at an IHS hospital

In a root cause analysis conducted by the hospital, staff described that local law enforcement officers and nursing staff in the emergency department (ED) forcibly restrained and catheterized a teenage patient to conduct a urine drug screening without consent by the patient or a legal guardian. Although the officers did not have legal support, according to the hospital's report, they ordered the test to gain medical clearance to transfer the patient to a youth shelter. In conducting the root cause analysis, the hospital identified several breakdowns that contributed to the incident, including lack of hospital policies, processes, and staff knowledge on patient rights of minors in police custody. The hospital developed a corrective action plan in response to the incident, which included updating its policies and staff training related to patient consent.

In September 2019, IHS issued a special general memorandum in the IHM reminding staff of the requirement to obtain informed consent prior to providing medical or surgical procedures or treatment. With limited exceptions, providers must inform patients about the procedures or treatment and ask for consent, which patients usually provide by signing a consent form. In the memo, IHS further clarified that law enforcement cannot order IHS staff to perform a medical procedure on a patient without the patient's informed consent, or in the case of a minor, the consent of a parent or guardian, unless there is a court order or search warrant signed by a Federal judge requiring the procedure.⁷⁷

Reporting Responsibilities. The IHM provided detailed guidelines on roles and responsibilities for reporting patient abuse. As outlined by the new policy guidelines, all staff must report, within 24 hours, any incident or reasonable suspicion of sexual abuse of a child by a healthcare provider directly to the appropriate child protective services (CPS) and/or law enforcement authorities, as well as the OIG hotline. Staff must also report to their supervisor or facility CEO and to the IHS hotline within the same day of the incident, and document the report in the IHS incident reporting system within 5 business days. The updated policies expand on the longstanding IHS policy provisions for reporting unethical and unprofessional conduct by expediting the reporting deadlines, which according to an IHS official, has resulted in IHS leadership "finding out about things much more rapidly than ever before." (See Exhibit 2 for IHS reporting responsibilities from the 2019 IHS policies on protecting children from sexual abuse.)

Exhibit 2: IHS Reporting Responsibilities for Incidents or Suspicions of Sexual Abuse of Children by Healthcare Providers



Source: IHS, *IHM*, pt. 3; Ch. 20; section 3-20.2 (Responsibilities). IHS training, *Protecting Children from Sexual Abuse in Health Care Settings – Supporting a Culture of Community Safety*, June 28, 2019.

Protections for Patients and Staff. The updated IHS policy provisions provide measures for ensuring confidentiality and protecting patients and staff involved in or affected by patient abuse allegations. The provisions stated that providers must immediately be removed from duties involving patient care when there is a report of child sexual abuse. An IHS official noted that in abuse cases, the number one priority is to protect patients and eliminate providers' access to more victims.

To remove access to patients, IHS officials explained that they would typically assign providers to administrative duties or place them on investigative leave, up to 90 days, while OIG investigates the allegation. To protect staff who report patient abuse, the updated policies included a non-retaliation clause that strictly prohibits any form of reprisal or coercion of those staff who report abuse. According to the provisions, retaliation against staff could result in disciplinary action.

Unlike the selected healthcare organizations, the IHS policies did not have guidelines for investigating allegations. However, in interviews, IHS officials reported that they deferred all criminal investigations to OIG because IHS staff are not trained investigators and should not conduct

internal investigations that could potentially jeopardize OIG’s criminal investigation. Officials explained that if OIG decides to pursue criminal action, the CEO of the facility where the alleged abuse took place, with input from OIG and in collaboration with the Area Office, would work with human resources staff to determine what, if any, administrative actions to take. If OIG determines that there is no criminal basis for an allegation, IHS could still take disciplinary action if the provider violated agency policies.

Gaps remain in IHS policy coverage for different types of abuse and circumstances

IHS’s updated policies address sexual abuse of children perpetrated by healthcare providers employed by or under contract with IHS. The agency defines a healthcare provider as anyone who provides physical or behavioral health treatment to patients (e.g., physicians, nurses, dentists, psychologists). We found that the policies did not explicitly address abuse by other types of IHS staff or contractors. In addition, the policies lacked provisions for other types of abuse, such as physical abuse that is not sexual in nature, and abuse against adult patients.

“We’ve had a lot of focus on healthcare providers and not enough focus on nonclinical staff.” – Area official

An IHS official explained that the reason for focusing on clinical providers was that the unique and powerful relationship that exists between providers and patients was thought to pose a greater risk. Leadership in one Area Office stated that focusing solely on providers addressed the immediate concern stemming from the Weber case, but did not address the vulnerability in protecting patients from abuse by other staff. As evidenced by a recent allegation involving an IHS maintenance worker and an underage patient at a youth residential substance abuse treatment facility, the potential for exploitation or abuse of patients is not limited to healthcare providers—any employee could be a potential perpetrator. Similarly, individuals other than children could be victims of abuse. A recent allegation of repeated abuse of an adult patient at an IHS hospital illustrates the importance of expanding policies to cover more types of abuse and adult patients. (See Exhibit 3 for further details regarding this case.)

Exhibit 3: A recent case of alleged patient abuse at an IHS hospital

During a recent CMS survey at an IHS hospital, surveyors found that an adult patient had, on multiple occasions, reported to hospital staff allegations of physical and verbal abuse committed by a nurse, and that the hospital failed to take action to protect the patient and investigate the allegations in a timely manner. Surveyors found that hospital staff did not file a grievance or report the allegations in WebCident, IHS's longstanding incident reporting system, and failed to adequately remove the nurse from the patient's care. Further, surveyors found that hospital officials had not trained staff on how to recognize, report, and investigate abuse. CMS cited the hospital with deficiencies at the immediate jeopardy-level for failing to "develop and implement policies and procedures to identify, report, investigate, and respond to allegations of patient abuse." CMS removed the immediate jeopardy one day later after verifying that the hospital had implemented an acceptable plan of correction.

Although the new IHS-wide policies are specific to sexual abuse of children by healthcare providers, some Area Offices and specific facilities may be applying them more broadly. For example, several Area Offices said they follow the same reporting structure for all patient abuse allegations, including those involving adult patients and other types of staff (e.g., administrative, maintenance). Leadership at one IHS facility described updating the facility's policies to include all types of abuse of minors (mental, physical, and sexual abuse and neglect) committed by any paid or unpaid staff working in the facility. In interviews, IHS HQ officials reported that they were in the process of assessing the agency-wide policies to possibly expand them to additional types of abuse, victims, and perpetrators.

While some IHS facilities have updated their facility-specific processes to align with the agency-wide policies, other facilities are still in early stages of revising their local policies

To ensure agency-wide adherence to the new policies, IHS required that facility CEOs establish local policies and procedures that incorporate the new policy content. This included creating guidelines for mandatory reporting to the appropriate child protective and law enforcement authorities (including OIG), Area Director, Area governing board, and IHS Office of Human Resources; and posting information for staff, patients, and caregivers about the reporting requirements that include the IHS and OIG hotlines. At the time of our review, Area Offices stated that healthcare facilities were at different stages of implementing the new policy provisions. According to Area officials, some facilities had fully incorporated the new guidelines into their existing policies, and others had yet to begin that process.

In implementing the updated policies, some facilities revised their local policies to both ensure compliance with the new IHS-wide requirements and to specify how they would be carried out within the facility's structure and systems and align with applicable State laws. In some facilities, these revisions resulted in guidelines that included more detail and were more comprehensive than the agency-wide policies.

For example, leadership at one facility described how they tailored the updated policies to fit the facility's reporting structure and align with State laws. As noted above, this included expanding the policy guidelines to include all types of abuse of minors committed by any staff working in the facility. The facility also added provisions to the chaperone guidelines, requiring providers to document, in the visit notes, the name of the chaperone who accompanied the provider or whether the patient refused a chaperone.

For those facilities that had yet to revise their local policies, IHS officials attributed the delay to staffing shortages and turnover of facility leadership.

In August 2019, IHS had a 21 percent vacancy rate across the agency; many of these vacancies included clinical staff. One official noted that some facilities struggled with the competing challenges of treating patients and finding time for training and education on new policies and procedures with the low staffing levels. Leadership in one Area Office also reported challenges in institutionalizing new practices because of staffing instability and expressed concerns about sustainability of policy and procedural changes at the facility-level.

"When you have acting or revolving leadership, that seems to be the biggest challenge to the operation of any health system, let alone enacting policies." – HQ official

Although IHS filled some of its vacancies with temporary contracted staff and leaders in "acting" capacity, in a 2019 OIG report that identified organizational challenges to improving quality of care in IHS hospitals, we found that temporary leaders sometimes struggled to institute policies because their newness to the position and temporary status made it difficult for them to understand the requirements and tasks at hand and enforce accountability. We also found that IHS officials considered it routine to operate outside of stated policies and procedures.⁷⁸ Our case study of the performance problems that led to the 7-month closure of the Rosebud Hospital emergency department, also issued in 2019, found that not long after IHS corrected the problems at the hospital, similar issues emerged when a new hospital leadership team arrived and did not follow policies and discontinued previously established improvement efforts.⁷⁹

Area Offices reported that they monitored facility adoption of the new agency-wide policies through their governing boards, and some reported assisting facilities in updating local policies. To ensure that facilities adopt and comply with the new policies, IHS requires Area Directors to review facility compliance on an annual basis. In interviews, Area Directors explained that they provided this oversight through their governing boards, chaired by Area Directors and composed of Area and facility leadership and staff. In one Area, where all facilities reportedly implemented the updated policy provisions, Area leadership described how they verified compliance by requiring facilities to demonstrate how the new guidelines were incorporated into their local policies and procedures.

In addition to oversight, some Area Offices reported providing guidance and assistance to help facilities incorporate the new guidelines into their local policies. For example, leadership in one Area Office reported that after receiving numerous inquiries about the new policies from facility staff who previously did not have mandatory reporting responsibilities, such as administrative staff, they developed guidance that detailed how to identify patient abuse warning signs and what to do if suspecting abuse.

Another Area Office reported that it was developing an Area-wide patient abuse and neglect policy to ensure that all facilities have a uniform policy that aligns with the new guidelines. The Area Director explained that this policy would replace individual facility policies and cover all patients, including adults, from abuse by anyone, including staff, students, volunteers, other patients, visitors, and family members. By having a uniform policy across the facilities, the Area Director believed that the Area Office could more easily assess its effectiveness and make updates as needed. The Area Director also noted that the Area Office had plans to share this policy with some of the tribally operated facilities in the Area who had expressed interest in adopting a similar policy.

IHS has trained staff on the updated policies directed at child sexual abuse but faces challenges to integrating these policies into practice and organizational culture

Shortly after issuing the new policies, IHS assembled a team of clinical subject matter experts and legal staff tasked with developing a comprehensive agency-wide training on the policy content and related reporting requirements. IHS launched the mandatory training in June 2019. To keep staff apprised of the revised policy provisions and training, IHS officials provided frequent updates and reminders through various means of communication, both directly and with the assistance of Area Offices and facility CEOs.

Despite these efforts, IHS officials reported barriers, both within IHS and among the patients and Tribal communities that the agency serves, that may discourage staff and patients from reporting patient abuse. Barriers for IHS staff include concerns about lack of anonymity in small facilities, fear of retaliation, lack of trust in appropriate response, traditional power discrepancies between physicians and other staff, and confusion about jurisdictional boundaries and reporting channels. Barriers for patients and their families include perceptions of power imbalances between IHS providers and patients, limited means of reporting in remote areas, language and communication barriers, and sensitivities and stigmas surrounding sexual abuse.

Efforts to promote an organizational culture of transparency and instill expectations for reporting and addressing problems are especially important given the circumstances of past and recent patient abuse cases, and OIG's prior findings about IHS's organizational challenges. OIG previously found that the agency's organizational culture did not always encourage candid discussion of problems, and breakdowns in communication between IHS HQ, Area Offices, and facilities sometimes affected the agency's ability to effectively address problems.^{80, 81}

Given the urgency and sensitivity of the new policies, IHS required all staff to complete mandatory web-based training, which some Area Offices supplemented with in-person training

The mandatory training, which all IHS employees and contractors had to complete by September 30, 2019, included information on indicators of abuse, warning signs and common perpetrator behaviors, organizational safeguards for ensuring patient safety, and reporting guidelines for suspected sexual abuse. To illustrate what suspicious provider behavior may look like, the training included different case scenarios that outlined the appropriate actions staff should take in such situations. IHS officials reported that they also included resources that staff could access if they struggled emotionally with the training content, given that the training could re-traumatize staff if they themselves had been victims of abuse. Officials stated that moving forward, the new training will be part of the agency's new employee orientation and annual training requirements.

At the time of our review, not all staff had completed the mandatory training, but Area Offices reported tracking facility completion to ensure that all staff met the September deadline. IHS officials noted that some facilities experienced challenges taking the web-based training because of staffing shortages and technical problems, such as not having enough bandwidth to effectively stream the training. One Area Director stated that bandwidth and cell phone coverage issues in remote facilities are critical challenges and limits the way information can be communicated across the agency.

Some Area Offices reported providing additional training at the facilities to clarify expectations and assess understanding of the new policy provisions. Leadership in one Area Office noted that the mandatory training was important to reach all employees, but training was most effective in person as it allowed Area leadership to gauge facility execution and understanding of the updated policies. Another Area Office explained that in-person training provided an opportunity for Area leadership to talk through potential abuse scenarios with facility staff and clarify roles and responsibilities.

“To drive a point, you need to provide opportunities for feedback, questions, problems, understanding...more human to human contact” – Area official

In some cases, Area Offices collaborated with other entities to provide the in-person training. For example, one Area Office reported working with Tribal CPS to educate facility staff on mandatory reporting requirements and was in the process of launching additional policy training led by regional human resources staff. Leadership in another Area Office reported coordinating training with OIG investigators to educate clinical staff on how to report suspected abuse and what information to include in the report, a training effort that the Area Office hoped to continue on an annual basis.

Despite IHS efforts to communicate policy requirements and create an organizational culture of transparency, barriers may discourage staff and patients from reporting abuse

To ensure that information on the new policies and training requirements reached everyone in the agency, IHS officials reported using multiple prongs, such as emails, meetings, videos, newsletters, and social media, to communicate with staff and leadership across the organization. As one official stated, the emphasis on the reporting requirements was infused in all communication from IHS HQ. Officials in one Area Office noted that IHS's efforts to prevent and address patient abuse significantly enhanced the agency's dissemination of information and increased communication

from IHS leadership, which was a positive change for the agency. From interviews, we also found that Area Offices and facility leadership played a large role in disseminating information across the agency through their chain of command and regular meetings with facility leadership and staff.

To keep Tribal communities informed of the updated policies, IHS officials reported communicating the new policy provisions with Tribal leaders during their monthly calls, in letters, and at national meetings. At the time of our review, IHS had held its annual National Combined Councils meeting, which providers of varying disciplines from IHS and Tribes attended to discuss the agency's clinical and administrative healthcare needs. An IHS official stated that the agency used this opportunity to again address the updated policies and remind the attendees of the mandatory reporting requirements.

According to an IHS official, the agency received several reports of patient abuse allegations following the issuance of the new policies and the agency-wide communication regarding the reporting requirements. IHS cited legal protections at 25 U.S.C. § 1675 as preventing public disclosure of how many reports it received, but one official stated that the agency should expect to see more reporting as it continues to develop a culture of transparency where employees feel safe to report issues.

Adding to the inherent time and effort needed to change the culture in any organization, IHS officials identified the following specific barriers to IHS staff and patients reporting abuse, which the agency must overcome to ensure that all patient abuse allegations are identified and addressed in a timely and effective manner.

Difficulty ensuring anonymity of reporters in small, remote facilities and fear of retaliation may discourage staff from forwarding abuse allegations.

Although the updated policies and mandatory training emphasize confidentiality and clearly state that reprisals are prohibited, officials stated that it can be challenging to ensure anonymity of staff who report patient abuse, particularly in small facilities in isolated communities where "everyone knows everyone." Because many staff are part of the communities they serve, they may be reluctant to report suspicious behaviors. Leadership in one Area Office further explained that staff may be discouraged from reporting if they are unsure about the consequences of the report for themselves and the suspect, especially if their suspicions are unsubstantiated, or if they lack trust in their supervisor to properly address their concerns.

“Truly feeling safe in reporting wrongdoing is probably the biggest barrier to overcome in people’s minds. I can’t say that retaliation is a problem, but the feelings about it is.” – HQ official

Traditional power discrepancies within the medical profession could make staff more hesitant to report suspected abuse. Leadership in one Area Office stated that there is a traditional power discrepancy in healthcare settings between doctors and other clinicians (e.g., nurses) who assist them, where the other clinicians may not feel empowered to question a doctor or report suspicious behavior because of the doctor’s perceived higher placement in the hierarchy. Such a barrier is crucial to address because as leadership in another Area Office stated, “nursing staff are the ones that really know the [doctors], the ins and outs, and how they’re interacting with the patients.” For similar reasons, one Area Director reported that in-person training at the facilities was important because it provided an opportunity to discuss the power dynamics and ensure that staff understood the trust relationship between providers and patients.

Confusion in some facilities about jurisdictional boundaries may also delay reports from getting to the appropriate authorities. An IHS official reported that variation in law enforcement jurisdictions across facilities may cause confusion for facility staff in identifying which law enforcement entity to contact for criminal matters, such as patient abuse. The official explained that in some locations, the Department of Interior or FBI may have jurisdiction, while in other areas, Tribal law enforcement agencies may have that authority. According to another official, confusion about jurisdictional boundaries recently caused reporting delays for an allegation involving employee-on-employee abuse.

Although IHS has emphasized in its agency-wide communication that staff must report all incidents to OIG, the facility staff contacted other law enforcement agencies, who after several weeks advised the facility to contact OIG, after determining that they were unable to investigate the incident. This caused a significant delay in OIG’s investigation of the incident. To address this issue, the Area Office sent a memo to all facilities in the Area, clarifying the reporting structure and the importance of immediately notifying OIG of any incidents. To avoid similar scenarios, one official suggested that IHS should conduct outreach to the various law enforcement agencies and discuss expectations and jurisdictions and clarify IHS’s role and responsibilities.

Perceived power imbalances between providers and patients, limited ways to report abuse, stigma, and language barriers may deter patients from reporting. Like some staff, some patients and their families may also be reluctant to report abuse involving providers in IHS facilities because they may not feel empowered to question an authority, such as a doctor, which one official stated makes patients who have this perception particularly vulnerable. Another official noted that some patients may not feel comfortable to raise concerns with facility staff in person and may lack phone and internet services to report abuse anonymously from the privacy of their home. The official stated that much of IHS's focus has been on staff reporting, but more should be done to ensure that patients and their families have multiple avenues for reporting abuse by IHS employees or contractors. IHS officials also reported that patients, and sometimes staff, may not recognize abuse and therefore may not know whether a provider's behavior was appropriate or if a medical exam was even needed.

"I'm always worried that there might be something else taking place that someone might be in fear of reporting." – HQ official

Furthermore, Area Offices noted that sensitivities and stigmas surrounding sexual abuse persist for some patients and in some Tribal communities, which could discourage reporting and exacerbate language and communication barriers. Leadership in one Area Office reported how the sensitive nature of sexual abuse was notably difficult when the Area Office tried to create signage on the new policy for healthcare facilities to post inside their buildings. Another Area Office described how language barriers sometimes created difficulties for Area and facility staff to communicate about patient abuse with certain Tribes whose native languages do not have words that correspond to the English language words. Such language barriers could be particularly challenging when communicating about something as important and sensitive as sexual abuse. To overcome language barriers and stigma, the Area Office reported working closely with Tribes in the Area to communicate information in their native languages and conducting outreach to school-based programs in Tribal communities to educate children about abuse and how to report such incidents.

IHS systems for storing and tracking patient abuse have shortcomings, and the agency has initiated efforts to strengthen systems and oversight

In the past few years, IHS began focusing more intensely on improving overall patient safety and oversight of its healthcare facilities, partially driven by the indictment of Dr. Weber. Part of the agency's efforts included awarding a contract to build a new incident reporting system to better track patient safety errors, adverse events, and abuse; establishing a new Office of Quality, responsible for the agency's quality- and safety-related work; and forming a new Quality Assurance Risk Management Committee, tasked with examining high-risk administrative and clinical incidents, including patient abuse. While these efforts are promising to improve the agency's ability to track patient abuse reports and address and prevent such incidents, some efforts had not been fully integrated or were under development at the time of our review. In the meantime, IHS is using reporting and tracking systems that have significant shortcomings.

Shortcomings in IHS's systems for storing and tracking patient abuse create inefficiencies and raise risks of ineffective or inappropriate handling of abuse allegations

The new policies on patient abuse require staff to report any incident or suspected sexual abuse of a child by a healthcare provider to the OIG and IHS hotlines and document the report in WebCident. The IHS hotline and WebCident operate independent of each other, and both require manual tracking and management of report data. The IHS Office of Human Resources operates the IHS hotline and receives reports by phone or through its website, and sometimes directly from OIG. The IHS Office of Quality operates WebCident and receives reports from IHS staff as well as patients and families. When the hotline receives an allegation, staff are to report the allegation immediately to OIG, notify IHS leadership through the Quality Assurance Risk Management Committee, and enter the information into WebCident.

From interviews, we identified shortcomings in this process that create inefficiencies and pose risks for the handling of patient abuse allegations:

- › *Reporting functions have no "central owner" or dedicated resources.* Some officials expressed confusion having multiple systems and individuals in different offices tracking patient abuse cases. As one official stated, it was unclear who was the "central owner" of all information and who should know what about the reports. Another official noted that the agency's new efforts were taxing on some officials and staff who now had to fill several roles because of the lack of designated positions and dedicated resources to perform such functions. In the 2019 OIG report that examined IHS's organizational structure, we found similar concerns about IHS officials and staff lacking clear roles and responsibilities. The lack of structure sometimes led to inefficiency and poor coordination.⁸² Unclear

ownership of patient abuse reports could result in overlooked reports and duplicative or inefficient efforts.

- › *Systems were not designed for patient abuse allegations.* According to IHS officials, the agency lacks a single, centralized system to capture all patient abuse reports, including those made to outside entities (e.g., law enforcement agencies), and does not have a reliable way to count abuse reports or compare such numbers over time. Neither the IHS hotline nor WebCident were designed to capture patient abuse reports. One official noted that the hotline was initially intended for waste, fraud, and management abuse but over time it evolved to include other types of abuse, including patient abuse. The official expressed concerns about this evolution because staff tasked with operating the hotline are not trained healthcare professionals. WebCident stores patient abuse reports and other types of incidents that any IHS employee can upload. According to IHS officials, the system is obsolete and was initially created for work-related events (e.g., employee injuries), but eventually evolved to include patient-related incidents. Not having systems specifically designed to capture patient abuse allegations could result in IHS inadvertently missing reports.
- › *IHS lacks capability to systematically track, categorize, and query data.* To ensure that the agency addressed all patient abuse allegations from the IHS hotline and WebCident, IHS officials reported assigning staff to monitor the systems and manually forward any reports of patient abuse to the newly formed Quality Assurance Risk Management Committee for review. IHS officials explained that the WebCident system is no longer supported and lacks the capability to categorize reports, query data, and send automatic notifications when a report is entered into the system. IHS dependence on manual monitoring of the systems and data extraction could lead to inefficiencies and error in data management. Given that all patient abuse reports are intended to be entered into WebCident, the lack of functionality of the system likely inhibits IHS staff responsible from identifying incidents efficiently and effectively.
- › *Systems and data may not be secure.* To track patient abuse reports received through the IHS hotline, staff described manually entering information into a spreadsheet, which one official noted was not ideal given that spreadsheets are like “notebook paper” that can be easily erased or modified. Staff also reported using a separate spreadsheet for reports forwarded from the OIG hotline. The lack of an established, secure database to track sensitive information, such as patient abuse and unsubstantiated allegations, could result in risks of inappropriate access, misuse of information, inadvertent or intentional overwriting or deleting of information.

At the time of our review, IHS was working with a contractor to develop a new and improved incident reporting system, estimated to be completed in late 2019 and rolled out in early 2020. Until IHS's launch of the new system, officials stated that the agency would continue to use WebCident and had assigned staff to conduct surveillance of the data, to ensure that no patient abuse reports in WebCident were missed. Due to WebCident's inability to query and systematically pull data, one official explained that staff manually conducted surveillance by using key word searches related to sexual abuse and assault. Some Area Offices also reported conducting daily surveillance of WebCident to ensure timely and proper response to any incidents at their facilities.

The new incident reporting system, specifically designed for patient safety and healthcare, is intended to provide IHS with real-time surveillance and added functionality

Through the new incident reporting system, which will reside in the Office of Quality, IHS expects to be able to track any patient-related incidents, including patient safety errors, adverse events, and abuse. Although the new incident reporting system is an improvement from WebCident, we found it unusual to include patient abuse incidents in the same system as clinical care types of events (e.g., medication errors, surgery infections). In a prior OIG report about hospital incident reporting systems nationwide, OIG found that all of the systems in sampled hospitals were designed to capture problems with clinical care. None of the hospital incident reports reviewed for that study included patient abuse reports.⁸³

In interviews, IHS officials described plans for the new incident reporting system to have specific fields for patient abuse with multiple drop-down menus and open text options to capture as many details as possible regarding an event. Unlike WebCident, IHS would be able to query reports and aggregate data from the new system, which would help the agency to identify potential patterns and vulnerabilities. All employees would be able to record incidents in the new system, but to maintain confidentiality, only certain staff and officials will have access to view report details.

While Area Offices would be able to view reports involving their individual facilities, leadership in IHS HQ will have access to all facility reports. Officials noted that the new incident reporting system would also have an automatic notification function for when incidents are recorded. For sexual abuse reporting, IHS plans to design a specific workflow, in which the system would email a select group of officials and staff and alert them of any new reports uploaded in the system, to ensure immediate response to such incidents.

IHS formed the Quality Assurance Risk Management Committee to enhance leadership oversight and management of patient abuse reports

In early 2019, IHS established a new committee, comprised of senior-level officials in IHS HQ, tasked with reviewing high-risk issues facing the agency, such as patient abuse allegations and significant fraud, waste, and abuse. An IHS official stated that the agency was working on finalizing the charter for the committee and explained that the intent for this new level of oversight was to ensure agency accountability, enhance effectiveness of reporting systems and processes, and expedite corrective actions.

At the time of our review, the committee convened several times per month to discuss new reports and ongoing efforts to resolve previously identified issues. During these meetings, the committee would look at agency policies and procedures to determine whether there were any gaps that IHS needed to address. To prepare for the meetings, one official reported compiling reports and relevant information from all available sources, including the IHS hotline, WebCident, and OIG, using a spreadsheet to track all high-risk incidents. IHS also shared this tracking spreadsheet with OIG investigators to ensure that they were informed of any incidents.

CONCLUSION AND RECOMMENDATIONS

Since the indictment of Dr. Weber in 2017, IHS has made important strides to address and prevent child sexual abuse in its healthcare facilities, strengthening its policies on patient protections and staff reporting responsibilities. IHS issued new policies specific to preventing and addressing child sexual abuse that, together with its other policies, address the types of protections set forth by nationally recognized professional organizations. However, the IHS policies have gaps in the types of abuse and circumstances that they cover.

IHS is also taking important steps toward integrating these policies into practice and organizational culture throughout IHS. For example, IHS provided mandatory training on the updated policy provisions to all staff and contractors employed by the agency. Some Area Offices and facilities have also updated their local policies and provided additional training to their staff. IHS is also bolstering its oversight of patient abuse reports and response through its newly established Quality Assurance Risk Management Committee.

However, IHS's successful implementation of these policies faces some significant challenges within and outside the organization. Staffing shortages and frequent changes in leadership for some facilities may inhibit agency-wide implementation and sustainability of the new policies and systems. The agency also faces challenges that may discourage staff and patients from reporting patient abuse, including difficulty ensuring anonymity, fear of retaliation, perceived or real power imbalances, and communication barriers, among others. In addition, IHS's current systems for storing and tracking patient abuse allegations fall short in ways that create inefficiencies and raise risks of ineffective or inappropriate handling of abuse allegations. To overcome these challenges, IHS must work with urgency to resolve barriers and ensure full incorporation of policies and systems into agency-wide practice and culture.

To address the issues identified in this report and further protect IHS patients from abuse, we make five new recommendations to IHS:

Extend policies to address more types of perpetrators, victims, and abuse

While it is understandable that IHS prioritized protections against sexual abuse of children by healthcare providers in updating its policies, it is crucial that IHS does not stop there. Given that abuse can take many forms, as evident in past and recent cases, IHS should further update its policies to explicitly address abuse by nonmedical staff and contractors, various types of abuse, and abuse of adults. Such policies could better

ensure reporting of and appropriate response to any type of abuse, consistent with the agency's zero-tolerance approach regarding abuse.

Ensure that the new incident reporting system is effective and addresses the risks identified in the current system

IHS has invested in improving its incident reporting system, but the system is still under development and has yet to be launched. Once the new system is implemented, IHS should assess how well it is working and whether it achieves its intended improvements to capture all allegations of patient abuse, including its capabilities to automatically notify appropriate leadership and staff of new abuse reports and query and aggregate data to identify potential patterns and vulnerabilities. Based on these assessments, IHS should update and make any necessary changes to the system, as needed.

To fully integrate the new incident reporting system across the agency, IHS should develop policies that provide guidance on how to operate the system, specifying relevant roles and responsibilities of staff and leadership across IHS. To ensure that staff at all levels of the agency are versed in the new system when launched, IHS should also provide agency-wide training on its use.

Designate a central owner in IHS HQ to ensure clear roles and responsibilities for shared ownership in implementing patient protection policies, and managing and responding to abuse reports

IHS has enhanced its oversight of patient abuse reports by manually conducting surveillance of the IHS hotline and WebCident and forming the senior-level Quality Assurance Risk Management Committee to review allegations of abuse. However, having multiple systems and staff in different offices tracking patient abuse cases on separate spreadsheets was sometimes confusing and burdensome on staff because there were no designated positions to carry out those tasks and it was unclear who was the central owner of all information.

To avoid confusion and overlap in tracking and managing patient abuse reports, IHS should designate a central owner in HQ to ensure clear roles and responsibilities for shared ownership in implementing patient protection policies, and managing and responding to abuse reports. This would improve coordination between the different offices and individuals involved and enhance oversight of agency-wide policy implementation. This could include adding provisions to new or existing policies that clearly define roles and actions to take when tracking and responding to allegations after abuse reports have been made.

Continue to actively promote an organizational culture of transparency and work to resolve barriers to staff reporting of abuse

Through increased communication and emphasis on reporting responsibilities for patient abuse, IHS leadership has begun efforts to instill a culture of transparency across the agency. This is a positive shift from the past, but culture change in any organization takes time and will need continued support to overcome deep-rooted challenges. OIG previously found that IHS's structure and organizational culture did not always provide IHS HQ with awareness and insight about problems that emerged at Area Offices and facilities and did not encourage candid discussion of problems, which sometimes inhibited the agency from making needed improvements. To address organizational challenges previously raised by OIG and in this report, IHS should examine its organizational culture and continue to promote a culture of openness and transparency that encourages staff to elevate concerns.

IHS should also develop and implement strategies to address barriers to staff reporting of abuse identified in this report, including issues of anonymity of reporters, fear of retaliation, power dynamics in facilities, and confusion about jurisdictional boundaries of law enforcement entities. IHS should also conduct outreach to the various law enforcement agencies with jurisdictions that cover IHS healthcare facilities and clarify IHS's role and responsibilities related to patient abuse, to ensure that abuse allegations receive immediate attention and are forwarded to the appropriate agencies (including IHS and OIG) in a timely manner.

Conduct additional outreach to Tribal communities to inform them of patient rights, solicit community concerns, and address barriers to reporting of patient abuse

IHS has communicated the new policies and related reporting requirements to Tribal communities, but IHS should do more to address barriers that may deter patients and their families from reporting abuse. To prevent any future patient abuse incidents to go unreported, IHS should conduct additional outreach to Tribes and other stakeholders and solicit community concerns to address stigma surrounding abuse, language barriers, and perceptions of power imbalance between providers and patients. IHS could collaborate with Tribal health organizations, CPS, schools, and other entities to educate Tribes on abuse and inform them of their rights. IHS should also assess whether there are sufficient means for patients to report abuse and consider whether to expand on such reporting avenues.

This evaluation also provides additional support and urgency to a prior OIG recommendation that IHS has not yet implemented.

Existing OIG recommendation that addresses these findings:

As a management priority, IHS should develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals

In July 2019, OIG recommended in our case study of the closure and reopening of the Rosebud Hospital emergency department that IHS, as a management priority, develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals. As noted by several officials in this report, IHS continues to struggle with maintaining an adequate workforce and consistent leadership in some facilities, which can affect all aspects of hospital operations, including policy implementation, adherence to policy requirements, and sustainability of improvements. It is important that IHS implement this recommendation, as well as the recommendations listed above, to ensure timely and effective response to patient abuse reports and to enhance strategies to prevent such incidents.

AGENCY COMMENTS AND OIG RESPONSE

IHS concurred with our recommendations, and reported actions taken and planned to implement the recommendations, as of December 2019.

In response to our first recommendation to extend policies to address more types of perpetrators, victims, and abuse, IHS reported that it is expanding IHM policies to include more types of potential perpetrators. IHS expects to issue these policy revisions in May 2020.

In response to our second recommendation to ensure that the new incident reporting system is effective and addresses the risks identified in the current system, IHS reported that it is testing the new system and has convened an implementation workgroup. IHS outlined a number of goals for the system, including strengthening management of incidents and ease of use. IHS also noted that it is developing performance metrics for the new system that will assist the agency with monitoring and system oversight. IHS reported that it expects to begin agency-wide training and deployment of the new incident reporting system in January 2020.

In response to our third recommendation to designate a central owner in IHS HQ to ensure clear roles and responsibilities for shared ownership in implementing patient protection policies, and managing and responding to abuse reports, IHS stated that its newly established Office of Quality is tasked to oversee patient safety activities and quality assurance, and provide shared leadership with the IHS Office of Clinical and Preventive Services in implementing patient protection policies. IHS also stated that it finalized a charter, in November 2019, for the Quality Assurance Risk Management Committee to provide senior-level oversight and management of high-risk clinical and administrative issues.

In response to our fourth recommendation to continue to actively promote an organizational culture of transparency and work to resolve barriers to staff reporting of abuse, IHS reported that it has provided training to promote and sustain a culture shift that supports staff who identify and appropriately report errors in IHS care. IHS also stated that the agency has provided training for all staff, including contractors, on the new policy guidelines for protecting children from sexual abuse by healthcare providers, and is developing guidance that will require all new employees to complete the training within 60 days of hire and on an annual basis for existing employees. The IHS Office of Human Resources is also developing an onboarding checklist for managers and new employees to ensure compliance with annual training requirements. IHS expects to complete the training guidance and onboarding checklist in January 2020.

In response to our fifth recommendation to conduct additional outreach to Tribal communities to inform them of patient rights, solicit community concerns, and address barriers to reporting of patient abuse, IHS reported that it will include information about reporting sexual abuse as a point of emphasis in all IHS leadership updates to Tribes. IHS also stated that it will launch a national information campaign in 2020 to educate Tribal communities on preventing and reporting sexual abuse of children. IHS will develop a website dedicated to this topic, as well as brochures and signage for facilities to use, that will include information about available resources and guidance on how to report allegations of sexual abuse. IHS also stated that it will solicit community concerns through various forums, including information sessions and town hall meetings, and will issue letters to Tribal and Urban Indian leaders in 2020 to provide updates on IHS activities, including the national information campaign.

In addition, IHS reported that it is on track to complete actions reported in the agency's response to OIG's prior recommendation to develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals. IHS reported that these actions include assembling a multidisciplinary, senior-level workgroup to develop a comprehensive workforce plan. The workforce plan, due for completion in mid-2020, will address recruitment, training, and placement of staff into leadership positions, particularly in remote locations, and succession planning.

OIG values the steps that IHS has taken, and will continue to assess progress updates from IHS in implementing these recommendations.

APPENDIX: Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

DEC 10 2019

Indian Health Service
Rockville, MD 20857

To: Acting Inspector General

From: Principal Deputy Director

Subject: IHS Comments on OIG Draft Report: *Indian Health Service Has Strengthened Patient Protection Policies but Must Fully Integrate Them Into Practice and Organizational Culture* (OEI-06-19-00330)

We appreciate the opportunity to review the Office of Inspector General (OIG) draft report entitled, "*Indian Health Service Has Strengthened Patient Protection Policies but Must Fully Integrate Them into Practice and Organizational Culture*" (OEI-06-19-00330), dated November 26, 2019. The Indian Health Service (IHS) appreciates the insights of the OIG and accepts all recommendations of this report. We are already actively working to implement many of the reforms identified here, on behalf of the patients we serve. Below you will find a status update of actions taken to date to implement the OIG recommendations and those planned in the near future.

OIG Recommendation No. 1: The IHS concurs with this recommendation.

Extend policies to address more types of victims, perpetrators and abuse.

Status of actions planned or taken to address Recommendation 1:

IHS is developing an update to Indian Health Manual, Part 3, Chapter 20, *Protecting Children from Sexual Abuse by Health Care Providers*, to expand the policy to include more types of potential perpetrators and broader prevention of patient abuse. We have already made progress in the development of this revised policy, and we expect to issue the revision no later than May, 2020.

OIG Recommendation No. 2: The IHS concurs with this recommendation.

Ensure that the new incident reporting system is effective and addresses the risks identified in the current system.

Status of actions planned or taken to address Recommendation 2:

WebCident limitations include restricted capabilities with regards to data analytics and patient safety reporting. The Agency is implementing a new adverse events reporting system, Datix, which addresses these issues and enables the IHS to support work flow tailored to tracking sexual abuse-specific incidents. In 2019, the IHS began pilot testing Datix at three facilities, with

IHS Comments on OIG Draft Report: *Indian Health Service Has Strengthened Patient Protection Policies but Must Fully Integrate Them Into Practice and Organizational Culture*

IHS-wide rollout anticipated in January 2020. The Agency has also convened an implementation workgroup comprised of members from across the IHS working with Datix to customize the software to reflect the IHS's case and workflow needs. Pilot testing of the new software is planned for December, 2019, with system-wide training and deployment to follow in January 2020. WebCident will continue to be available for use during this transition.

The benefits of the Datix adverse event reporting system include: 1) strengthening incident management to identify errors and develop actions to address patient, worker, and visitor safety; 2) enhanced ease of use; 3) improve data quality; and 4) improve reports and dashboard tracking. Reporting, which includes both patient safety and occupational safety events, will be available for all IHS programs to electronically report incidents 24 hours per day, 7 days per week. The reports will be used at the local, regional, and IHS Headquarters (HQ) levels.

The IHS is developing performance metrics for Datix that will assist in continued monitoring and system oversight. Proposed measures include: 1) increased number of adverse events by 100 percent over baseline reporting established from WebCident annual reporting rate; 2) reduce time required for entry of a completed report by 20 percent compared to the median WebCident reporting time; 3) assure system is in an operational state for reporting more than 99 percent of the time (i.e., limit downtime to less than 1 percent); and 4) limit downtime duration to less than 8 hours.

OIG Recommendation No. 3: The IHS concurs with this recommendation.

Designate a central owner in IHS HQ to ensure clear roles and responsibilities for shared ownership in implementing patient protection policies, and managing and responding to abuse reports.

Status of actions planned or taken to address Recommendation 3:

The executive sponsor in IHS HQ to oversee patient safety activities and provide shared leadership with the IHS Office of Clinical and Preventive Services to implement patient protection policies, is the newly established IHS Office of Quality (OQ). The IHS OQ was officially approved in January 2019. Below are a few of the IHS OQ's recent accomplishments in 2019 and planned activities for 2020.

To provide senior level oversight and management for the highest risk clinical and administrative issues, the OQ has established the Quality Assurance Risk Management Committee (QARMC). The QARMC Charter was signed by the IHS Principal Deputy Director on November 18, 2019, and the committee is actively reviewing cases. The QARMC meets monthly to review the highest risk events and continuously monitor implementation of patient protection policies.

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The OQ Division of Quality Assurance provides Governing Board accreditation standards to facilities and IHS Area Directors and provides technical assistance to the local level to ensure these standards are met. Through regular communication with Areas and Governing Boards, the OQ identifies and shares best practices for Governing Board operations, while offering specific training sessions to Governing Boards to improve adherence to policies. The OQ maintains ongoing communication with Service Unit and Area staff to ensure Governing Board adherence to policies.

The OQ monitors quality assurance across all facilities. The OQ provides support to facilities to maintain continual survey readiness through training sessions on standards and regulations, and maintains a database of external accreditation and certification status of all IHS facilities. In fiscal year (FY) 2019 The Joint Commission (TJC) completed 12 surveys with no *high risk likely to harm* findings. In FY 2019, four Joint Commission Resources mock surveys were completed with IHS hospitals. Post-survey support is provided through consultation, root cause analysis assistance, and conditions of participation support.

OIG Recommendation No. 4: IHS concurs with this recommendation.

Continue to actively promote an organizational culture of transparency, and work to resolve barriers to staff reporting of abuse.

Status of actions planned or taken to address Recommendation 4:

In alignment with the *IHS Strategic Plan FY 2019-2023*, the Agency has taken actions to promote and sustain a culture shift that commends and supports staff who identify and appropriately report on errors within all levels of care within the IHS system. The Agency is providing ongoing training on *Just Culture* and *TeamSTEPPS*, which promotes a culture of patient safety by educating and encouraging staff to report on errors. In 2019, seven *TeamSTEPPS* training sessions were held in IHS hospitals and clinics. Three *TeamSTEPPS* train-the-trainer courses are scheduled for January 2020.

The IHS has also taken steps to build a culture where patient and staff safety is an imperative. For example, the IHS issued a new policy in the *Indian Health Manual*, Part 3, Chapter 20, *Protecting Children from Sexual Abuse by Health Care Providers*. The IHS issued an additional policy in September 2019, which provides supplemental guidance to ensure contractors are accountable for this mandatory training. The IHS is developing a similar supplemental policy to require all new Federal employees to complete this mandatory training within 60 days of hire and all current Federal employees to complete annual training. The target date for completion of the Federal employee training guidance is January 31, 2020.

The IHS Office of Human Resources is developing an onboarding checklist for managers and new employees. The checklist outlines key activities, information, and training to be completed by specified timeframes. This checklist will further ensure compliance with annual training

requirements and communication on policy. The target date for completion of the onboarding checklist is January 31, 2020.

OIG Recommendation No. 5: The IHS concurs with this recommendation.

Conduct additional outreach to Tribal communities to inform them of patient rights, solicit community concerns, and address barriers to reporting of patient abuse.

Status of actions planned or taken to address Recommendation 5:

The IHS will conduct outreach to Tribal communities to inform them of patient rights. The IHS will institutionalize standard messaging by including how to report sexual abuse as a point of emphasis in all IHS leadership updates to Tribes. For example, the IHS will continue to share this messaging during monthly Tribal and Urban Leader conference calls held with IHS senior leadership.

The IHS will also address barriers to patient abuse reporting. The IHS will launch a national information campaign during the summer of 2020 to educate Tribal communities on prevention of sexual abuse of children. Distinct messaging on how to identify and report sexual abuse will be created to educate and reach different audiences such as Tribes and Urban Indian organizations, patients, and IHS employees. The main platform for this information will be a Web site dedicated to this topic. The IHS plans to develop and release a video that features the IHS Principal Deputy Director promoting the importance of protecting patients, along with information on available resources, and how to report sexual abuse. Template materials, such as brochures and signage, will be developed and deployed at IHS facilities.

The IHS will solicit community concerns. In conjunction with the launch of the educational campaign described above, the IHS will focus on receiving feedback from Tribal communities through various forums, such as Consultation with Tribes and Confer sessions with Urban Indian Organizations, seeking guidance from IHS Tribal Advisory Committees, and holding information sessions and town hall meetings. Examples of these forums include: the Direct Service Tribal Advisory Committee meeting in February 2020 and Tribal Self-Governance Advisory Committee meeting in July 2020. The IHS will issue letters to Tribal and Urban Indian leaders by August 2020, which will provide updates on IHS activities, including information about the national campaign.

Additional OIG Focus on Prior Report Recommendation

The OIG also emphasized in this draft report, the IHS's need to fully address a priority recommendation from the *OIG Rosebud Case Study Report, OIG OEI 16-17-00270*. The IHS is on track to complete and implement actions referenced in the official response to that recommendation.

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OIG OEI 16-17-00270 Recommendation No. 1:

As a management priority, develop and implement a staffing program for recruiting, retaining, and transitioning staff and leadership to remote hospitals.

Actions taken and planned actions as of December 9, 2019

The IHS concurred with this recommendation. In February 2019, the IHS published a 5-year Strategic Plan for fiscal year (FY) 2019 through FY 2023. *Objective 1.1 of the Strategic Plan: "Recruit, develop, and retain a dedicated, competent, and caring workforce"* demonstrates the Agency's commitment to recruit and retain quality staff throughout the IHS, including hospitals. As a part of the implementation plan for this objective, the IHS Principal Deputy Director will identify a multi-disciplinary, senior-level working group to develop a comprehensive workforce plan to address the recruitment, training, and placement of staff into hospital leadership positions, particularly in remote locations. The comprehensive workforce plan will also include a component for succession planning, which is a factor in recruitment and retention for these sites. The target date for completion of the comprehensive workforce plan is May 2020.

If you have specific questions about this response, or would like to request documentation to support the information provided, please contact Mr. Jonathan Merrell, Deputy Director for Quality Health Care, IHS, by telephone at (301) 443-1083, or Ms. Athena Elliott, Director, Office of Management Services, IHS, by telephone at (301) 443-5104.



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ACKNOWLEDGMENTS

Petra Nealy served as the team leader for this study, and Kristen Calille and John Van Der Schans served as the lead analysts. Others in the Office of Evaluation and Inspections who conducted the study include Demetri Martinez and Savanna Thielbar. Office of Evaluation and Inspections staff who provided support include Joe Chiarenzelli and Kevin Farber.

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To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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